APPLICATION FOR FINANCIAL ASSISTANCE

2017 Federal Poverty Guidelines				Charity Care at 125%												
Family Size	Annual Income	Minimum Monthly Income	Maximum Monthly Income	Annual Income	Minimum Monthly Income	Maximum Monthly Income	Dependents 1	2	3	4	5	6	7	8	9	10	11	12
1	12,060		1,005	15,075		1,256	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2	16,240	1,006	1,353	20,300	1,257	1,692	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
3	20,420	1,354	1,702	25,525	1,693	2,127	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
4	24,600	1,703	2,050	30,750	2,128	2,563	0.0%	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
5	28,780	2,051	2,398	35,975	2,564	2,998	0.0%	0.0%	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6	32,960	2,399	2,747	41,200	2,999	3,433	0.0%	0.0%	0.0%	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
7	37,140	2,748	3,095	46,425	3,434	3,869	0.0%	0.0%	0.0%	0.0%	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
8	41,320	3,096	3,443	51,650	3,870	4,304	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%
9	45,500	3,444	3,792	56,875	4,305	4,740	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%
10	49,680	3,793	4,140	62,100	4,741	5,175	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	75.0%	100.0%	100.0%	100.0%
11	53,860	4,141	4,488	67,325	5,176	5,610	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	75.0%	100.0%	100.0%
12	58,040	4,489	4,837	72,550	5,611	6,046	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	75.0%	100.0%

***Add $4,180.00 for each additional family member with more than 6 members**
Effective Discounts for Dates of Service after 1/24/2017.

*** Income verification may be requested and may include pay stubs or other documents containing income information for the appropriate time period (3 and 12 months prior to hospital services). Charity determination is based on income 6 months prior to the date of application.**

Date of Application_____

Patient Name_____

Responsible Party, if not patient _____ Applicant Phone # _____

Patient Date of Birth _____ Patient SS# (optional) _____

Street Address_____

City _____ State_____ Zip _____

Date(s) of hospital service: From _____ To _____

Are you an Ohio Resident at the time of your hospital services?..... Yes ☐ No ☐

Were you an active Ohio Medicaid recipient at the time of your hospital services?..... Yes ☐ No ☐

If yes, please provide Ohio Medicaid recipient ID Number _____

Were you an active recipient of Ohio Disability Assistance at the time of your hospital service? ..... Yes ☐ No ☐

If yes, please attach a copy of your OHIO DA card effective during your hospital service to this application.

Did you have health insurance (other than medicare) at the time of your hospital service?..... Yes ☐ No ☐

Please provide the following information for all of the people in your immediate family who live in your home. **"Family" is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the parent's home**.

Name (Please include self)	Date of Birth	Relationship to Patient	Income for 3 mo prior to hospital service	Income for 12 mo prior to hospital service	Type of Income Verification*
(SELF)					

Please check here if your total checking and savings accounts balance is greater than $10,000. ☐

Total persons in family	Total family income 3 months	Total family income 12 months

If you report $0 income provide a brief explanation of the following lines:

I had zero income from _____ to_____. My means of survival during this time was _____

_____

_____

By my signature below, I certify that everything I have stated on this application and on my attachment is true.

Responsible Party/Patient Signature: _____ Date: _____

For information regarding our Financial Assistance Policy and Financial Assistance Application Form, please contact our representatives in our Patient Accounting Department located at 1207B 17th Street, Portsmouth, Ohio or call (740) 356-7639.